

**TITLE 10. CALIFORNIA CODE OF REGULATIONS**  
**CHAPTER 5.6. ACCESS FOR INFANTS AND MOTHERS PROGRAM**

**ARTICLE 1. DEFINITIONS**

2699.100. Definitions

- (a) "Appellant" means an applicant or subscriber who has filed an appeal with the program.
- (b) "Applicant" means a pregnant woman 18 years of age or older who is applying on her own behalf, or a legal guardian or a natural parent, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. "Applicant" also means a pregnant woman who is applying for coverage on her own behalf who is under 18 years of age, or who is an emancipated minor, or who is a minor not living in the home of a natural or adoptive parent, a legal guardian, foster parent or stepparent.
- (c) "Application Date" means the date an application is sent to the program as evidenced by the U.S. postmark date on the application envelope, or documentation from other delivery services including fax delivery.
- (d) "Board" means the Managed Risk Medical Insurance Board.
- (e) "Coverage" means the payment for benefits provided through the program.
- (f) "Disenroll" means to terminate coverage by the program.
- (g) "Eligible" means the applicant is qualified to be enrolled in a participating health plan.
- (h) "Enroll" means to accept an applicant as a subscriber by notifying a participating health plan to accept the applicant.
- (i) "Executive Director" means the executive director for the Board.
- (j) "Family member" means the following persons living in the individual's home:
  - (1) Children under age 21, of married or unmarried parents living in the home.
  - (2) The married or unmarried parents of the child or sibling children.

- (3) The stepparents of the sibling children.
- (4) The separate children of either an unmarried parent or a married parent or stepparent.
- (5) An unborn child of the pregnant woman who is applying for coverage on her own behalf or on whose behalf an application has been submitted.
- (6) Children under the age of 21, of married or unmarried parents, away at school who are claimed as tax dependents.
- (7) The spouse of the pregnant woman.
- (k) "Federal poverty level" means the level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.
- (l) "Gross household income" means the total annual gross income of all family members except dependent children. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, self-employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability worker's compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes child support, public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.
- (m) "Healthy Families Program" (HFP) means the Federal/State funded program that is operated pursuant to Title XXI of the Social Security Act and Part 6.2 (commencing with Section 12693) of Division 2 of the California Insurance Code, and that provides low cost health, dental and vision insurance coverage to eligible children.

- (n) "Income deduction" means any of the following:
- (1) Work expenses of \$90 per month for each family member except dependent children working or receiving disability workers' compensation or State Disability Insurance. If a family member earns less than \$90, the deduction can only be for the amount earned.
  - (2) Child care expenses while a family member works or trains for a job of up to \$200 per month for each family member under age 2, up to \$175 per month for each family member over age 2 and disabled dependent care expenses of up to \$175 for a disabled dependent living in the home.
  - (3) The amount paid by a family member per month for any court ordered alimony or child support.
  - (4) \$50 for alimony payments received by the pregnant woman. If a woman receives less than \$50, the deduction can only be for the amount received.
- (o) "Infant" means a subscriber's child born to a subscriber while the subscriber is enrolled in the program.
- (p) "Living in the home" means using the home as the primary place of residence.
- (p) "Medi-Cal" means the California health care services program under Title XIX of the Social Security Act.
- (r) "Medicare" means the Health Insurance for the aged and permanently disabled provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in Title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.
- (s) "Participating health plan" means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:
- (1) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

- (2) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.
  - (3) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).
  - (4) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.
  - (5) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.
  - (6) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.
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- (t) "Program" means the Access for Infants and Mothers Program.
  - (u) "Resident" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes.
  - (v) "Subscriber" means an individual who is eligible for and enrolled in the program.
  - (w) "Subscriber contribution" means the cost to the subscriber to participate in the program.
  - (x) "Tenses and Number". The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.
  - (y) "Time". Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12695, 12695.06, 12695.08, 12695.18, 12695.20, 12695.22, 12695.24, 12696 and 12698, Insurance Code.

## ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

### 2699.200. Basis of Eligibility

- (a) All eligibility requirements contained herein shall be applied without regard to race, creed, color, sexual orientation, health status, national origin, occupation, or occupational history of the individual applying for the program.
- (b) To be eligible for the program, an individual shall meet the requirements of either (1) or (2):
  - (1) Meet all of the following requirements:
    - (A) Be certified as pregnant by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse physician's assistant, nurse midwife, vocational nurse, or medical assistant, and have a reasonable good faith belief that the pregnancy is not beyond the 30th week of gestation as of the application date; and
    - (B) Be a resident of the state of California and have been a resident for at least six continuous months immediately prior to the date of signing the application; and
    - (C) Have a monthly household income after income deductions that is above 200 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level at the time of application; and
    - (D) Pay the first portion of the subscriber contribution, which shall be fifty dollars (\$50), and agree to the payment of the complete subscriber contribution; and
    - (E) Not be reimbursed by any health care provider or any state or local governmental entity for payment of the subscriber contribution and not have any health care provider or state or local governmental entity pay the subscriber contribution; and
    - (F) Not be a beneficiary of either no-cost Medi-Cal or Medicare Part A and Part B as of the application date; and

- (G) Not be covered for maternity benefits in a private insurance arrangement as of the application date. A pregnant woman in a private insurance arrangement with a separate maternity only deductible or copayment greater than \$500 shall be deemed not covered for maternity benefits for purposes of determining eligibility.
- (2) Be an infant of less than two (2) years of age born to a program subscriber who was enrolled prior to July 1, 2004, and reside in California.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05, 12698, 12698.05, and 12698.06, Insurance Code.

2699.201. Application

- (a) To apply for the program an individual shall submit:
  - (1) All information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this section; and
  - (2) A cashier's check or money order for fifty dollars (\$50.00); and
  - (3) A statement signed by the applicant agreeing that if the pregnant woman is enrolled, the applicant will pay the full subscriber contribution and acknowledging that the program will take aggressive action to collect the full subscriber contribution.
- (b) The applicant shall sign and date a declaration stating that the information is true and accurate to the best of his or her knowledge.
- (c) The applicant will be notified in writing that the application is incomplete and what documentation is required for completion.
- (d) (1) The application, entitled Access for Infants and Mothers (AIM) Application (rev 6/04), which is incorporated by reference, shall contain the following:
  - (A) The pregnant woman's full name,
  - (B) The pregnant woman's current living address including house or building number (and unit number if applicable), street, city, county, state, and zip code, and phone number,
  - (C) The pregnant woman's date of birth,

- (D) The pregnant woman's social security number (provision of the Social Security number is not mandatory),
- (E) The pregnant woman's ethnicity and primary language (not mandatory),
- (F) Certification by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, nurse midwife, vocational nurse, or medical assistant, that the woman on whose behalf the application is filed is pregnant,
- (G) The first day of the pregnant woman's last menstrual period,
- (H) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, beyond the 30th week of gestation in a current pregnancy, as of the application date,
- (I) Information about whether the applicant or anyone in the household smokes,
- (J) The address to which the bills for the subscriber's contribution are to be sent, if different from the current living address,
- (K) A list of all family members living in the home, their ages, and relationship to the pregnant woman,
- (L) A list of those family members, and their social security numbers excluding dependent children, living in the home who had income in the previous or current calendar year, (provision of the social security number is not mandatory),
- (M) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person listed in (L) above, provide documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:
  - 1. For the previous calendar year:
    - a. Federal tax return. If self-employed, a schedule C must be included.

- b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, ~~or~~ bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.
2. For the current calendar year:
- a. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:
    - i. The employee's name.
    - ii. The employer's business name, business address and phone number.
    - iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.
    - iv. A statement that the information presented is true and correct to the best of the signer's knowledge.
    - v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

- b. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.
- c. If self employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:
  - i. Date.
  - ii. Name, address and telephone number of the business.
  - iii. Gross income, gross expenses, and net profit itemized on a monthly basis.
  - iv. A statement on the profit and loss, signed by the person who earned the income, which states, "the information provided is true and correct."
- d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:
  - i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,
  - ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.100, and
  - iii. A determination of the number of family members living in the household.
- e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance

(RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income for the previous month.

- (N) The name of each family member living in the home who pays court ordered child support or court ordered alimony. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of alimony paid, child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.
- (O) A declaration that the pregnant woman is not a beneficiary of either no-cost Medi-Cal or Part A and Part B of Medicare,
- (P) A declaration that the pregnant woman has been a resident of the State of California for six (6) continuous months immediately prior to the date of the signing of the application,
- (Q) A declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the pregnant woman is enrolled,
- (R) Information about any health coverage that is in effect for the pregnant woman or will be in effect for the infant, including the name, address, and policy number of the current insurance or health plan,
- (S) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, covered for maternity benefits in a private insurance arrangement. A pregnant woman with a separate, maternity only deductible or co-payment greater than \$500 shall be deemed not covered for maternity benefits for purposes of this declaration,

- (T) Name and address of the primary employer of each adult family member who is employed,
  - (U) Information about health coverage available to the applicant, spouse, or father of the baby who is in the household,
  - (V) A declaration that the applicant has reviewed the benefits offered by the participating health plans,
  - (W) A declaration that the applicant understands and will follow the rules and regulations of the program,
  - (X) A declaration that the applicant is giving permission for the program to verify family income, health insurance, residence, and other circumstances,
  - (Y) A declaration that the subscriber is not being, and will not be, reimbursed by any health care provider or any state and local governmental entity for payment of the subscriber contribution and that no health care provider or state or local governmental entity is paying or will pay the subscriber contribution,
  - (Z) An indication of the pregnant woman's first choice and second choice participating health plans,
  - (AA) A declaration that the subscriber agrees to pay the required subscriber contribution, even if the subscriber does not take full advantage of the coverage or services.
  - (BB) A declaration that the information and documentation submitted is true and correct to the best of the applicant's knowledge.
- (2) The Social Security number and other personal information are needed for identification and administrative purposes.
  - (3) If applicable, the applicant's signed authorization to forward the application to the Medi-Cal Program in the county in which the applicant resides for a determination of eligibility for no-cost Medi-Cal.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12698 and 12698.05, Insurance Code.

**2699.202. Initial Review of Application**

Upon receipt of an application the program shall determine if there is funding available for additional enrollment in the program.

- (a) If there is no funding available the application shall be rejected and returned.
- (b) If there is funding available the application shall be reviewed for completeness.
  - (1) If it is not complete a telephone call will be placed to the applicant to request the missing information and documentation. If the applicant is reached, the applicant will be asked to provide the necessary information and documentation. If the applicant is not reached by telephone, a letter will be mailed to the applicant indicating the required information and/or documentation needed to complete the application. The applicant must provide all information and/or documentation necessary for the application to be completed within 17 calendar days from the date the application was received by the program and prior to the 30<sup>th</sup> week of gestation, and the applicant will be so notified.
  - (2) If the application submitted is not complete and it is not completed within seventeen (17) calendar days and prior to the 30<sup>th</sup> week of gestation, the application shall be denied. The applicant shall be sent a notice indicating that their application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.
  - (3) If it is complete it will be reviewed for an eligibility determination pursuant to Section 2699.203.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05 and 12696.15, Insurance Code.

**2699.203. Determination of Eligibility**

- (a) The program shall determine the applicant's eligibility based upon the criteria specified in Section 2699.200. The program shall complete the application review process within 10 calendar days of receipt of the complete application.
- (b) Applicants determined ineligible shall be notified in writing by the program. The notice shall include the reason for the determination of ineligibility and

an explanation of the appeal process. The first portion of the applicant's subscriber contribution shall be refunded.

- (c) Applicants determined eligible shall be enrolled.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12696.05, Insurance Code.

2699.204. Enrollment

- (a) Applicants determined eligible for the program shall be enrolled in their:
- (1) First choice participating health plan, unless that plan is currently serving the number of subscribers which it has contracted with the program to serve.
  - (2) Second choice participating health plan when the first choice plan is currently serving the number of subscribers which it has contracted with the program to serve.
- (b) An applicant shall be notified in writing by the program of enrollment with a participating health plan and the beginning date of coverage by the participating health plan.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, and 12696.05, Insurance Code.

2699.205. Registration of Infants

- (a) For infants born to subscribers who are enrolled prior to July 1, 2004, the subscriber shall register the infant as follows:
- (1) Within thirty (30) days of the birth of an infant, the subscriber shall notify her health plan in writing of the following information about the infant:
    - (A) Name; and
    - (B) Date of birth; and
    - (C) Sex; and
    - (D) Weight at birth.
  - (2) Within thirty (30) days prior to an infant's first birthday, the subscriber shall notify the program in writing if the subscriber

wishes to disenroll the infant from the program. If notification is not received, the child is automatically enrolled for the second year.

- (b) For infants born to subscribers who are enrolled on or after July 1, 2004, the subscriber shall register the infant in the Healthy Families Program as follows:
  - (1) Upon the birth of the infant, the subscriber shall provide to the Healthy Families Program the required premium and provide the following information about the infant:
    - (A) Name; and
    - (B) Date of birth; and
    - (C) Sex; and
    - (D) For infants born on or after July 1, 2007:
      - 1. Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and
      - 2. Information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date in which coverage terminated, and the reason for termination.
  - (2) The Healthy Families Program shall request the infant's birth weight and primary care provider from the subscriber.
  - (3) Subject to all requirements specified in the statute and regulations governing the Healthy Families Program, the infant will be enrolled in the Healthy Families Program with coverage effective on the date of the infant's birth.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12693.765 and 12696, Insurance Code.

**2699.206. Change of Address and/or Phone Number**

An applicant shall notify the program in writing within thirty (30) days of any change of the applicant's billing address or any change of residence or phone number of a person participating in the program.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.

**2699.207. Disenrollment**

- (a) A subscriber and/or infant shall be disenrolled from the program and from the program's participating health plan when any of the following occur:
  - (1) The subscriber so requests in writing.
  - (2) The subscriber becomes ineligible because:
    - (A) The subscriber fails to meet the residency requirement; or
    - (B) The subscriber has committed an act of fraud to circumvent the statutes or regulations of the program,
    - (C) The subscriber is no longer pregnant on her effective date of coverage. If notification to the program is received after the effective date, documentation by a licensed or certified healthcare professional must be submitted indicating the date of the miscarriage.
  - (3) The infant becomes ineligible because the infant fails to meet the residency requirement.
- (b) A subscriber shall be notified by the program in writing of the disenrollment of the subscriber and/or infant from the program, the effective date, and the reason for the disenrollment.
- (c) Except for Section 2699.207(a)(2)(C), disenrollment shall take effect at the end of the calendar month in which the request was received or at the end of a future calendar month as requested by the applicant. Disenrollment pursuant to Section 2699.207(a)(2)(C) shall take effect upon the date that would have been the effective date of coverage.
- (d) Once a subscriber and/or infant is disenrolled pursuant to Section 2699.207(a), the subscriber and/or infant cannot be re-enrolled for the same pregnancy.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698, Insurance Code.

**2699.208. Continuation of Benefits.**

Infants shall be eligible to continue coverage in the program from a participating health plan if the subscriber is deceased or becomes ineligible for reasons other than an act of fraud while the infant is otherwise eligible.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

**2699.209. Coverage**

- (a) The date on which the coverage shall begin shall be no later than ten (10) calendar days from the date the applicant is enrolled. Coverage shall not begin if the pregnancy terminates prior to the effective date of coverage.
- (b) Coverage in the program for the subscriber shall be for one pregnancy and shall include services following the pregnancy for sixty (60) days. The subscriber shall be notified of the date her coverage ends and such notice will be provided at least twenty (20) days prior to that date.
- (c) Coverage in the program for an infant born to a subscriber who is enrolled prior to July 1, 2004 shall be for two (2) years from the date of the birth of the child.
- (d) Notwithstanding subsections (b) and (c) above, coverage in the program for either the subscriber or the infant will cease at disenrollment.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

**2699.210. Transfer of Enrollment**

- (a) A subscriber and/or infant, if any, shall be transferred from one participating health plan to another if any of the following occurs:
  - (1) The subscriber so requests, in writing, because the subscriber and/or infant, if any, has moved and no longer resides in an area served by the participating health plan in which the subscriber and/or infant, if any, is enrolled, and there is at least one participating health plan serving the area in which the subscriber and/or infant now resides that is accepting new enrollees.
  - (2) The subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber-plan relationship and the Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating health plan serving the area in which the subscriber resides that is accepting new enrollees.

- (3) The program contract with the participating health plan in which the subscriber is enrolled is canceled or not renewed.
- (b) The effective date of transfers pursuant to subsection (a)(1) of this section shall be:
  - (1) On the first day of a month following the transfer request for an infant, if the request is received on or before the 10<sup>th</sup> of the month. Transfer of enrollment shall take effect on the first day of the second month following the transfer request for an infant, if the request is received after the 10<sup>th</sup> of the month.
  - (2) Within seventeen (17) calendar days of receipt of the transfer request for the subscriber.
- (c) The effective date of transfers pursuant to subsection (a)(2) of this section shall be:
  - (1) On the first day of a month following the approval of the transfer request for an infant, if the approval is made on or before the 10<sup>th</sup> of the month. Transfer of enrollment shall take effect on the first day of the second month following the approval of the transfer request for an infant, if the approval is made after the 10<sup>th</sup> of the month.
  - (2) Within fifteen (15) calendar days from approval of the transfer request for the subscriber.
- (d) The effective date of transfers pursuant to subsection (a)(3) of this section shall be prior to the end of the contract.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12697.10, Insurance Code.

**2699.211. Payment for Application Assistance**

- (a) The program shall pay an insurance agent as defined in Section 31 of the Insurance Code, or broker as defined in Section 33 of the Insurance Code, or a licensed general acute care hospital, or a licensed medical doctor, or a licensed doctor of osteopathy, or a registered nurse, or a county health department, or a county welfare department, or a licensed day care operator, or a licensed primary care community clinic, or a direct state maternal and child health contractor, or a participating health plan, or a licensed chiropractor for assisting an individual in completing the application form, if the following conditions are met:

- (1) The individual is enrolled as a result of the application; and
  - (2) The request for payment is made in writing and specifies to whom the payment shall be made; and
  - (3) Such request accompanies the application and includes the name, position/title and address and, if applicable, the license number of the person who assists in the completion of the application and the tax identification number of the person/entity to be paid. An incomplete request will be rejected; information missing from the application cannot be submitted at a later date.
- (b) The amount of such payment shall be fifty dollars (\$50.00).

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code

### ARTICLE 3. SCOPE OF BENEFITS

2699.300. Minimum Scope of Benefits

- (a) The basic scope of benefits offered by participating health plans to subscribers and infants must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.301. No other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. The basic scope of benefits shall be as follows:

(1) Health Facilities

- (A) Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy, respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

- (B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes physical, occupational, and speech therapy as appropriate; and those hospital services, which can reasonably be provided on an ambulatory basis. Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

- (2) Durable medical equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is

generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

- (3) Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital, which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through "911" emergency response system.

Non-emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when:

- (A) medically necessary, and
- (B) requested by a plan provider, and
- (C) authorized in advance by the participating health plan

Exclusions: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

- (4) Emergency Health Care Services: Twenty-four hour emergency care for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (A) Placing the patient's health in serious jeopardy.
- (B) Serious impairment to bodily functions.
- (C) Serious dysfunction of any bodily organ or part.

This must be provided both in and out of the health plan service area and in and out of the health plan's participating facilities.

- (5) Professional Services: Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary. In addition, professional services include:

- (A) Eye Examinations: Eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.
- (B) Hearing tests, hearing aids and services: Hearing tests, hearing aids and services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid. Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices.

- (C) Immunizations for infants: Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the American Academy of Pediatrics, the Advisory Committee

on Immunization Practices (ACIP), and the American Academy of Family Physicians. Immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Immunizations for Subscribers: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

- (D) Periodic health examinations for infants: periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the current version of the Recommended Childhood Immunization Schedule/United States, adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the infant including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Periodic Health Examinations for Subscribers: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations.

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

- (E) Well baby care during the first two years of life, including newborn hospital visits, health examinations and other office visits.

- (6) Health education services: Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan. Health education services include services related to tobacco use and drug and alcohol abuse.

Health education services relating to tobacco use means tobacco use prevention and education services including tobacco use cessation services.

- (7) Nutrition Services: Direct patient care nutrition services, including nutritional assessment.
- (8) Prescription Drugs: Medically necessary prescription drugs, when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins, if such vitamins require a prescription. Medically necessary drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy. Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable cost (MAC) method, and mail order programs by health plans is encouraged.

Contraceptive Drugs and Devices: All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.

Exclusions: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as

previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU), and appetite suppressants or any other diet drugs or medications.

- (9) **Reconstructive Surgery:** Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do any of the following:

- (A) To improve function
- (B) To create a normal appearance to the extent possible
- (C) To restore and achieve symmetry incident to mastectomy. Services for this purpose include reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury, and breast prosthesis required incidental to the surgery.

- (10) **Transplants:**

Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants. Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

- (11) **Maternity Care:** Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized. Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.
- (12) **Family Planning:** Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by

state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

- (13) **Diagnostic X-ray and laboratory Services:** Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).
- (14) **Home Health Services:** Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy); and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings. Exclusions: Custodial care

- (15) **Physical, Occupational, and Speech Therapy:** Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.
- (16) **Blood and Blood Products:** Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

Includes the collection and storage of autologous blood when medically indicated.

- (17) **Cataract Spectacles and Lenses:** Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens.
- (18) **Skilled Nursing:** Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.
- (19) **Hospice:** The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include physical therapy; occupational therapy, speech therapy, short-term inpatient care, pain control and symptom management. The hospice benefit may include, at the option of the health plan, homemaker services; services of volunteers, and short-term inpatient respite care. The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

- (20) **Orthotics and Prosthetics:** Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear

for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

(21) Mental Health:

- (A) Inpatient: Plans must provide services with no visit limits for severe mental illnesses including Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa, and services for serious emotional disturbances in children. Plans must provide coverage for up to 30 days per benefit year for illnesses that do not meet the criteria for severe mental illnesses, and for conditions that do not meet the criteria for serious emotional disturbances of a child.

Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

- (B) Outpatient: Plans must provide services with no visit limits for severe mental illnesses including Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa, and services for serious emotional disturbances in children.

Plans must provide up to 20 visits per benefit year for illnesses that do not meet the criteria for severe mental illness or serious emotional disturbances of a child. Participating plans may elect to provide additional visits. Plans may provide group therapy at a reduced copayment.

(22) Alcohol and Drug Abuse:

- (A) Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.
  - (B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. Participating health plans shall offer at least 20 visits per benefit year. Participating health plans may elect to provide additional visits.
- (b) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

2699.301. Excluded Benefits

- (a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:
  - (1) Services which are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:
    - (A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and
    - (B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and
    - (C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

- (D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.
- (2) Any services which are received prior to the enrollee's effective date of coverage, except as provided in Section 2699.303.
- (3) Custodial care, domiciliary care, or rest cures, for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
- (4) Personal or comfort items, or a private room in a hospital unless medically necessary.
- (5) Emergency facility services for nonemergency conditions.
- (6) Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:
  - (A) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.
  - (B) Outmoded or not efficacious.
- (7) Transportation except as specified in Section 2699.300(a)(3).
- (8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in Section 2699.300(a)(9)(C).
- (9) Eyeglasses, except those eyeglasses or contact lenses necessary after cataract surgery, which are covered under Subsection 2699.300(a)(17).
- (10) Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section

does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Subsection 2699.300(a)(18) and (19).

- (11) Dental services, including dental treatment for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible. This language shall not be construed to exclude surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.
- (12) Cosmetic surgery, including treatment for complications of cosmetic surgery, that is solely performed to alter or reshape normal structures of the body in order to improve appearance, except as specifically provided in Section 2699.300(a)(9).
- (13) Any services or items specified as excluded within Section 2699.300.
- (14) Any benefits in excess of limits specified in Section 2699.300.
- (15) Treatment for infertility is excluded. Diagnosis of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
- (16) Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which such benefits are provided or payable under any Worker's Compensation benefit plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.
- (17) Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

**2699.302. Pre-Existing Conditions Exclusion and Postenrollment Waiting Period.**

Subscribers and infants shall not be subject to any pre-existing condition exclusion period or postenrollment waiting period.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

**2699.303. Services Received Prior to Enrollment**

- (a) Subscribers may be reimbursed up to a total of one hundred and twenty-five dollars (\$125.00) for pregnancy-related medically necessary services, including but not limited to pregnancy test and initial prenatal visit, received in the time period beginning forty (40) calendar days prior to the application date that a complete application is received by the program and ending on the beginning date of coverage.
- (b) Requests for payment pursuant to this section shall be submitted by the subscriber within ninety (90) calendar days of the date service was provided and shall include the following information:
  - (1) An original bill which includes the name, and business address of the medical doctor, doctor of osteopathy, registered nurse, pharmacist or physician's assistant, or laboratory providing the service,
  - (2) Name, address, date of birth and social security number (not mandatory) of the subscriber for whom services were provided,
  - (3) Date service was provided,
  - (4) Type of service provided,

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12698.25, Insurance Code.

**2699.304. Order of Benefit Determination**

The coverage of this program shall not duplicate and shall pay secondary to any other valid and collectible medical coverage, except Medi-Cal.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12698.06, Insurance Code.

#### ARTICLE 4. SUBSCRIBER CONTRIBUTIONS

2699.400. Subscriber Contributions

- (a) Subscriber contributions shall be:
  - (1) An initial fifty dollars (\$50.00) to be submitted with the application; and
  - (2) For subscribers who are enrolled prior to July 1, 2004, the difference between two percent (2%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars (\$50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment; and
  - (3) For infants born to subscribers who are enrolled prior to July 1, 2004, one hundred dollars (\$100.00) which shall be due on the infant's first birthday unless either of following apply:
    - (A) The infant is disenrolled from the program prior to the infant's first birthday, or
    - (B) The subscriber provides written proof that the infant is current for the infant's first year immunizations. Such immunizations shall be consistent with the most current version of the Recommended Childhood Immunization Schedule jointly adopted by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. The written proof of completed current first year immunizations shall be signed by a licensed medical doctor, licensed doctor of osteopathy, registered nurse, or licensed physician's assistant. When such written notice is provided the amount shall be fifty dollars (\$50.00).
  - (4) For subscribers who are enrolled on or after July 1, 2004, the difference between one and one-half percent (1.5%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars (\$50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment.
- (b) There shall be no penalty for early payment of any portion of the subscriber contribution.

- (c) In cases of multiple births to a subscriber, the \$100 payment shall apply to each infant born to a subscriber who is enrolled prior to July 1, 2004.
- (d) Subscribers shall not be reimbursed by any health care provider or state or local governmental entity for payment of the subscriber contribution and shall not have any health care provider or state or local governmental entity pay the subscriber contribution.
- (e) No portion of the subscriber contribution is refundable except as provided in Sections 2699.202 and 2699.203 or unless the subscriber is disenrolled pursuant to Subsection 2699.207(a)(2)(C).
- (f) A federally recognized California Indian Tribal Government may make required subscriber and infant contributions on behalf of a member of the tribe.
- (g) An applicant in arrears of subscriber contributions shall be sent a reminder notice. Applicants who become ninety (90) days in arrears on subscriber contributions will be reported to a credit reporting agency. If accounts are paid in full at a later date, the credit reporting agency's records shall be updated.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05, and 12698, Insurance Code.

**2699.401. Discount for Prepayment of Subscriber Contribution**

The subscriber contribution amount shall be reduced by fifty dollars (\$50) if the subscriber submits the total annual subscriber contribution amount described in Section 2699.400(a)(2) and Section 2699.400(a)(4), with her application.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.

## ARTICLE 5. APPEALS

### 2699.500. Appeals to the Board

- (a) If a subscriber is dissatisfied with any action or failure to act which has occurred in connection with a participating health plan's coverage the subscriber's remedy shall be to file an appeal with the Board.
- (b) In addition, the following decisions may be appealed to the Executive Director only:
  - (1) A program determination as to eligibility of any applicant.
  - (2) A program determination to disenroll a subscriber or infant from the program.
  - (3) A program determination to deny a subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

### 2699.501. Dispute Resolution

Notwithstanding other sections in this Article, when a subscriber is dissatisfied with any action, or inaction, of the program's participating health plan in which she is enrolled, the subscriber shall first attempt to resolve the dispute with the participating health plan according to its established policies and procedures.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.

### 2699.502. Filing an Appeal

- (a) An appeal shall be filed in writing with the Executive Director within sixty (60) calendar days of the action or failure to act or receipt of notice of the decision being appealed.
- (b) An appeal shall include all of the following:
  - (1) A copy of any decision being appealed; or a written statement of the action or failure to act being appealed;
  - (2) A statement specifically describing the issues which are disputed by the appellant;

- (3) A statement of the resolution requested by the appellant; and
- (4) Any other relevant information the appellant wants to include.
- (c) Any appeal that does not include all necessary information shall be returned to the applicant or subscriber without review. The applicant or subscriber may re-submit the appeal. The resubmittal shall be filed within the time limits of subsection (a) or within twenty (20) calendar days of the receipt of the returned appeal, whichever is later.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

**2699.503. Administrative Review**

- (a) Any appeal filed pursuant to this Article will be given an administrative review.
- (b) Administrative reviews of appeals shall be conducted by the Executive Director.
- (c) In conducting an administrative review of an appeal, the Executive Director may contact the appellant and/or the participating health plan for further information.
- (d) The Executive Director's decision shall be in writing.
- (e) If an appeal was filed pursuant to section 2699.500(a), the appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the Executive Director. Such a request shall be filed within thirty (30) calendar days of receipt of the Executive Director's decision. It shall include a clear and concise statement of what action is being appealed, and the reason(s) the Executive Director's decision is not correct.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

**2699.504. Hearings**

When an appeal which requests an administrative hearing is received, the appeal shall be set for hearing as follows:

- (a) Administrative hearings of appeals will be conducted according to the appeal procedures, including pre- and post-hearing procedures, set forth in Chapter 2.5 (commencing with section 251) of Division 2 of Title 1 of the

California Code of Regulations. Chapter 2.5, as adopted on June 4, 1984, is hereby incorporated by reference, subject to the following modifications:

1. Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.
  2. Reference to the private non-profit human service organization shall be deemed reference to the petitioner.
  3. Reference to the grievance procedure established in accordance with Health and Safety Code section 38036 shall be deemed reference to the administrative review process set forth in section 2699.503.
  4. Reference to Health and Safety Code sections providing the bases, grounds, authorization or procedures for appeals shall be deemed reference to the bases and authorization for appeal found in section 2699.500, and the appeal procedures found in this section.
  5. The 30-day time period specified in section 251(b) shall be extended to 60 days, and the 10-day time period in section 252(a) shall be extended to 30 days.
  6. If the proposed decision submitted to the Board is not adopted as the decision, the Board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.
  7. The decision of the Board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.
- (b) The Board may elect to have a hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.